Seating/Mobility Evaluation

To be completed by Physiatrist or Physical/Occupational Therapist

PATIENT INFORMATION:

Name:	**DOB:** **Sex:**	**Date Seen:** **Time:**
Address:	**Physician:** **Seating Therapist:** **Phone:**	***This evaluation/justification form will serve as the LMN for the following suppliers*:** _____ **Supplier:** Contact Person: Phone:
Phone:	**Primary Therapist:**	
Spouse/Parent/Caregiver Name: **Phone Number:**	**Insurance/Payer:** **Recipient #**	**Rehabilitation Engineering Program or 2nd Supplier** Contact Person: Phone :
Reason for Referral		
Patient Goals:		
Caregiver Goals and Specific Limitations that May Effect Care:		

MEDICAL HISTORY:

Diagnosis:	ICD9 Code:	**Primary Diagnosis**: **Onset:**	ICD9 Code:	Diagnosis:	
	ICD9 Code:	Diagnosis:	ICD9 Code:	Diagnosis:	
❒Progressive Disease	**Relevant Past and Future Surgeries**:				
Height:	**Weight:**	Explain Recent Changes or Trends in Weight:			
History:					
Cardio Status: Functional Limitations:					
❒Intact ❒ Impaired ❒ Severely Impaired ❒ NA					
Respiratory Status: Functional Limitations:					
❒Intact ❒Impaired ❒ Severely Impaired ❒ NA					
Orthotics: **Amputee** ❒ Yes ❒ No					

HOME ENVIRONMENT:

❒House❒ Condo/Town Home ❒Apartment ❒Asst Living ❒LTCF ❒Own ❒Rent
❒Lives Alone ❒ Lives with Others Hours with caregiver:
❒Home is Accessible to Equipment Storage of Wheelchair: ❒In Home ❒Other Stairs ❒ Yes ❒ No ***Comments:***

Patient Name:

COMMUNITY ADL:

TRANSPORTATION:

❒Car ❒Van ❒Public Transportation ❒Adapted W/C Lift ❒ Ambulance ❒Other: ❒Sits in Wheelchair During Transport

Where is W/C Stored During Transport? ❒Tie Downs

❒Self Driver Drive While in Wheelchair ❒Yes ❒No

Employment:
Specific Requirements Pertaining to Mobility

School:
Specific Requirements Pertaining to Mobility

Other:

FUNCTIONAL/SENSORY PROCESSING SKILLS:

Handedness: ❒Right ❒Left ❒NA Comments:

Functional Processing Skills for Wheeled Mobility
❒Processing Skills are Adequate for Safe Wheelchair Operation
Comments:

COMMUNICATION:

Verbal Communication ❒WFL Receptive ❒ WFL Expressive ❒Understandable ❒Difficult to Understand ❒Non-Communicative
❒Uses an Augmentative Communication Device Manufacturer/Model :

AAC Mount Needed:

SENSATION and SKIN ISSUES:

Sensation
❒Intact ❒Impaired ❒Absent
❒Hyposensate ❒Hypersensate
❒Defensiveness
Level of sensation:

Pressure Relief:
Able to Perform Effective Pressure Relief : ❒Yes ❒ No
Method:
If not, Why?:

Skin Issues/Skin Integrity
Current Skin Issues ❒Yes ❒No
❒Intact ❒ Red Area❒ Open Area
❒Scar Tissue ❒At Risk from Prolonged Sitting
Where _____

History of Skin Issues ❒Yes ❒No
Where _____
When _____

Hx of Skin Flap Surgeries ❒Yes ❒No
Where _____
When _____

Complaint of Pain: Please Describe

ADL STATUS (In Reference to Wheelchair Use):

	Indep	Assist	Unable	Indep with Equip	Not Assessed	Comments
Dressing						
Eating						Describe Oral Motor Skills
Grooming/Hygiene						
Meal Prep						
IADLS						
Bowel Mngmnt: ❒Continent ❒Incontinent ❒Accidents						Comments:
Bladder Mngmnt: ❒Continent ❒Incontinent ❒Accidents						Comments:

Patient Name:

CURRENT SEATING / MOBILITY:

Current Mobility Base: ❒None ❒Dependent ❒Dependent with Tilt ❒Manual ❒Scooter ❒Power Type of Control:		
Manufacturer:	Model:	Serial #:
Size:	Color:	Age:
Current Condition of Mobility Base:		
Current Seating System:		Age of Seating System:

COMPONENT	MANUFACTURER/CONDITION
Seat Base	
Cushion	
Back	
Lateral Trunk Supports	
Thigh Support	
Knee Support	
Foot Support	
Foot Strap	
Head Support	
Pelvic Stabilization	
Anterior Chest/Shoulder Support	
UE Support	
Other	
When Relevant:	Overall Seat Height / Overall W/C Length / Overall W/C Width

Describe Posture in Present Seating System:

WHEELCHAIR SKILLS: (Shown by Trial)

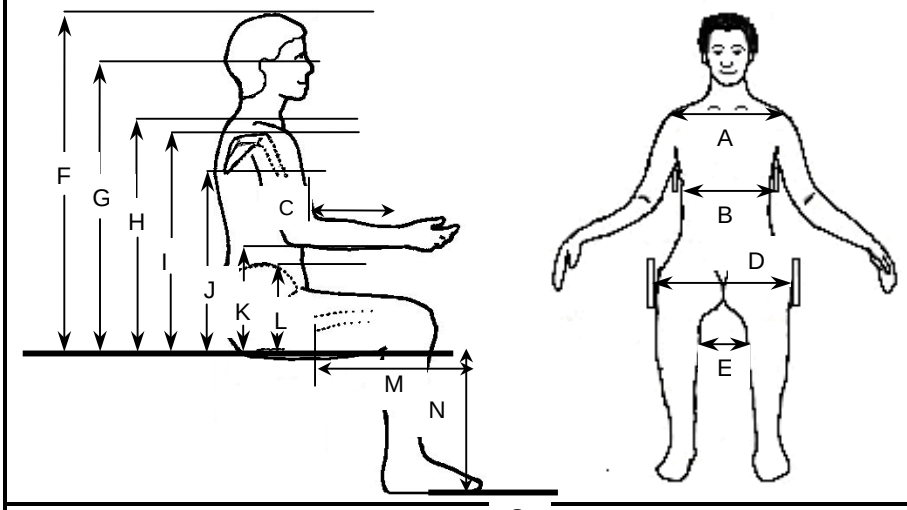
	Indep	Assist	Dependent/ Unable	N/A	Comments
Bed ↔ W/C Chair Transfers	❒	❒	❒	❒	
w/c ↔ Commode Transfers	❒	❒	❒	❒	
Manual w/c Propulsion:	❒ UE or LE Strength and Endurance Sufficient to Participate in ADLs Using Manual Wheelchair				Arm : ❒Left ❒Right ❒Both Foot: ❒Left ❒Right ❒Both
Operate Scooter	❒ Strength, Hand Grip, Balance , Transfer Appropriate for Use. ❒ Living Environment Appropriate for Scooter Use.				
Operate Power W/C: Std. Joystick	❒	❒	❒	❒	❒Safe ❒ Functional Distance
Operate Power W/C: w/ Alternative Controls	❒	❒	❒	❒	❒Safe ❒ Functional Distance

MOBILITY/BALANCE:

Balance		Transfers	Ambulation
Sitting Balance:	Standing Balance	❒ Independent	❒ Independent
❒ WFL	❒ WFL	❒ Min Assist	❒ Ambulates with Asst
❒Uses UE for Balance in Sitting	❒Min Assist	❒ Mod Asst	❒ Ambulates with Device
❒ Min Assist	❒ Mod Assist	❒Max Assist	❒ Indep. Short Distance Only
❒ Mod Assist	❒Max Assist	❒ Dependent	❒ Unable to Ambulate
❒Max Assist	❒ Unable	❒ Sliding Board	
❒ Unable		❒ Lift / Sling Required	
Comments:			

Patient Name:

MAT EVALUATION:



	Measurements in Sitting:	Left	Right		
	A: Shoulder Width				
	B: Chest Width			**H:**	Seat to Top of Shoulder
	C: Chest Depth (Front – Back)			**I:**	Acromium Process (Tip of Shoulder)
	D. Hip width			**J:**	Inferior Angle of Scapula
	E. Between Knees			**K:**	Seat to Elbow
	F. Top of Head			**L:**	Seat to Iliac Crest
	G. Occiput			**M:**	Upper leg length
	++ Overall width (asymmetrical width for windswept legs or scoliotic posture			**N:**	Lower leg length
				O:	Foot Length

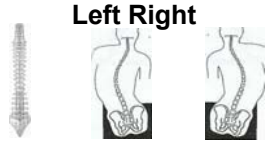
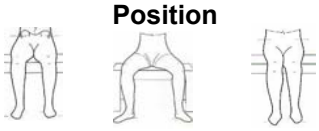
Additional Comments:

Hamstring flexibility: Pelvis to thigh angle ❒accommodate greater than 90 **Thigh to calf angle** ❒ accommodate less than 90

DESCRIBE REFLEXES/TONAL INFLUENCE ON BODY:

EXPLAIN WHY PATIENT IS NON-AMBULATORY:

Patient Name:

POSTURE:				COMMENTS:
PELVIS	**Anterior / Posterior**  ❒ Neutral ❒ Posterior ❒ Anterior ❒ Fixed ❒ Other ❒ Partly Flexible ❒ Flexible	**Obliquity**  ❒ WFL ❒ R elev ❒ l elev ❒ Fixed ❒ Other ❒ Partly Flexible ❒ Flexible	**Rotation-Pelvis**  ❒ WFL ❒ Right Anterior ❒ Left Anterior ❒ Fixed ❒ Other ❒ Partly Flexible ❒ Flexible	
TRUNK	**Anterior / Posterior**  ❒ WFL ❒ ↑ Thoracic Kyphosis ❒ ↑ Lumbar Lordosis ❒ Fixed ❒ Flexible ❒ Partly Flexible ❒ Other	**Left Right**  ❒ WFL ❒ Convex Left ❒ Convex Right ❒c-curve ❒s-curve ❒multiple ❒ Fixed ❒ Flexible ❒ Partly Flexible ❒ Other	**Rotation-shoulders and upper trunk**  ❒ Neutral ❒ Left-anterior ❒ Right-anterior ❒ Fixed ❒ Flexible ❒ Partly Flexible ❒ Other	
	Describe LE Neurological Influence/Tone:			
HIPS	**Position**  ❒ Neutral ❒ ABduct ❒ ADduct ❒ Fixed ❒ Subluxed ❒ Partly Flexible ❒ Dislocated ❒ Flexible	**Windswept**  ❒ Neutral ❒ Right ❒ Left ❒ Fixed ❒ Other ❒ Partly Flexible ❒ Flexible	**Hip Flexion/Extension Limitations:** **Hip Internal/External Range of motion Limitations:**	
KNEES & FEET	**Knee R.O.M.** Left ❒ WFL ❒Limitations Right ❒ WFL ❒Limitations		**Foot Positioning** ❒ WFL ❒L ❒R ROM concerns: Dorsi-Flexed ❒L ❒R Plantar Flexed ❒L ❒R Inversion ❒L ❒R Eversion ❒L ❒R	

Patient Name:

POSTURE:				COMMENTS:
HEAD & NECK	❒ Functional ❒ Flexed ❒ Extended ❒ Rotated L ❒ Lat Flexed L ❒ Rotated R ❒ Lat Flexed R ❒ Cervical Hyperextension	❒ Good Head Control ❒ Adequate Head Control ❒ Limited Head Control ❒ Absent Head Control	**Describe Tone/Movement of head and Neck:**	
UPPER EXTREMITY	**SHOULDERS** **Left** **Right** ❒Functional ❒Functional ❒elev / dep ❒elev / dep ❒pro-retract ❒pro-retract ❒subluxed ❒subluxed	**R.O.M. for Upper Extremity** ❒WNL ❒WFL Limitations: **UE Strength (X/5):** ❒ **N/A** ❒ **None** ❒**Concerns:**	**Describe Tone/Movement of UE:**	
	ELBOWS **Left** **Right**	**R.O.M.** **Strength (X/5)** **Strength concerns:**		
WRIST & HAND	**Left** **Right** ❒Fisting	**Strength / Dexterity: (X/5)**		

Goals for Wheelchair Mobility

- ❒ Independence with mobility in the home and motor related ADLs (MRADLs) in the community
- ❒ Independence with MRADLs in the community
- ❒ Provide dependent mobility
- ❒ Provide recline
- ❒Provide tilt ❒

Goals for Seating system

- ❒ Optimize pressure distribution
- ❒ Provide support needed to facilitate function or safety
- ❒ Provide corrective forces to assist with maintaining or improving posture
- ❒ Accommodate client's posture: current seated postures and positions are not flexible or wilnot tolerate corrective forces
- ❒ Client to be independent with relieving pressure in the wheelchair
- ❒Enhance physiological function such as breathing, swallowing, digestion

Equipment trials:

State why other equipment was unsuccessful:

Patient Name:

MOBILITY BASE RECOMMENDATIONS and JUSTIFICATION

MOBILITY BASE	JUSTIFICATION	
Manufacturer: **Model:** **Color:** Size: Width Seat Depth	❒provide transport from point A to B ❒promote Indep mobility ❒is not a safe, functional ambulator ❒walker or cane inadequate	❒non-standard width/depth necessary to accommodate anatomical measurement ❒
❒Manual Mobility Base	❒non-functional ambulator	
❒Scooter/POV	❒can safely operate ❒can safely transfer	❒has adequate trunk stability ❒can not functionally propel manual wheelchair
❒Power Mobility Base	❒non-ambulatory ❒can not functionally propel manual wheelchair	❒ can not functionally and safely operate scooter/POV
❒Stroller Base	❒infant/child ❒unable to propel manual wheelchair ❒allows for growth	❒non-functional ambulator ❒non-functional UE ❒ Indep mobility is not a goal at this time
Tilt Base or added ❒Forward ❒Backward ❒Powered tilt on powered chair ❒Powered tilt on manual chair ❒Manual tilt on manual base	❒ change position against gravitational force on head and shoulders ❒change position for pressure relief/can not weight shift ❒transfers	❒management of tone ❒rest periods ❒control edema ❒facilitate postural control ❒
Recline ❒Power recline on power base ❒Manual recline on manual base	❒ accommodate femur to back angle ❒ bring to full recline for ADL care ❒ change position for pressure relief/can not weight shift	❒rest periods ❒repositioning for transfers or clothing/diaper /catheter changes ❒head positioning
❒Transportation tie-down option	❒to provide crash tested tie down brackets	
Elevator on Mobility Base ❒Wheelchair ❒Scooter	❒increase Indep in transfers ❒increase Indep in ADLs	❒raise height for communication at standing level ❒
Push handles ❒extended ❒angle adjustable ❒standard	❒caregiver access ❒caregiver assist	❒allows “hooking” to enable increased ability to perform ADLs or maintain balance
Lighter weight required	❒self propulsion ❒lifting	❒
Heavy Duty required	❒user weight greater than 250 pounds ❒extreme tone ❒over active movement	❒broken frame on previous chair ❒multiple seat functions ❒
Specific seat height required Floor to seat height	❒foot propulsion ❒transfers ❒accommodation of leg length	❒access to table or desk top ❒
Rear wheel placement/Axle adjustability ❒None ❒semi adjustable ❒fully adjustable	❒improved UE access to wheels ❒improved stability ❒changing angle in space for improvement of postural stability	❒1-arm drive access ❒amputee placement ❒

Patient Name:

MOBILITY BASE	JUSTIFICATION	
Angle Adjustable Back	❒postural control ❒control of tone/spasticity ❒accommodation of range of motion	❒UE functional control ❒accommodation for seating system ❒
POWER WHEELCHAIR CONTROLS ❒**Proportional** Type Body Parts Left Right ❒**Non-Proportional/switches** Type Body Parts **Upgraded Electronics** ❒ ❒**Display box** ❒Digital interface electronics ❒ASL Head Array ❒**Sip and puff tubing kit** ❒Upgraded tracking electronics ❒**Safety Reset Switches** ❒Single or Multiple Actuator Control Module	❒provides access for controlling wheelchair ❒ lacks motor control to operate proportional drive control ❒ unable to understand proportional controls ❒programming for accurate control ❒progressive Disease/changing condition ❒Needed in order to operate power/tilt through joystick control ❒Allows user to see in which mode and drive the wheelchair is set; necessary for alternate controls ❒Allows w/c to operate when using alternative drive controls ❒Allows client to operate wheelchair through switches placed in tri-panel headrest ❒needed to operate sip and puff drive controls ❒increase safety when driving ❒ correct tracking when on uneven surfaces ❒Used to change modes and stop the wheelchair when driving in latch mode ❒ Allow the client to operate the power seat function(s) through the joystick control	❒non-proportional drive control needed
❒Mount for switches or joystick	❒Attaches switches to w/c ❒Swing away for access or transfers	❒midline for optimal placement ❒provides for consistent access
Attendant controlled joystick plus mount	❒safety ❒long distance driving ❒operation of seat functions	❒compliance with transportation regulations ❒
Battery	❒power motor on wheelchair	

Patient Name:

MOBILITY BASE	JUSTIFICATION	
Charger	❒charge battery for wheelchair	
Push rim active assist	❒enable propulsion of manual wheelchair on sloped terrain	❒enable propulsion of manual wheelchair for distance
Hangers/ Leg rests ❒60 ❒70 ❒90 ❒elevating ❒heavy duty ❒articulating ❒fixed ❒lift off ❒swing away ❒rotational hanger brackets ❒adjustable knee angle ❒adjustable calf panel ❒ Longer extension tube	❒provide LE support ❒accommodate to hamstring tightness ❒elevate legs during recline ❒provide change in position for Les ❒Maintain placement of feet on footplate	❒durability ❒enable transfers ❒decrease edema ❒Accommodate lower leg length ❒
Foot support ❒adjustable Footplate ❒R ❒L ❒flip up ❒depth/angle adjustable	❒provide foot support ❒accommodate to ankle ROM ❒allow foot to go under wheelchair base	❒transfers ❒
Armrests ❒fixed ❒adjustable height ❒removable ❒swing away ❒flip back ❒reclining ❒full length pads ❒desk ❒pads tubular	❒provide support with elbow at 90 ❒provide support for w/c tray ❒change of height/angles for variable activities	❒remove for transfers ❒allow to come closer to table top ❒remove for access to tables ❒
Side guards	❒prevent clothing getting caught in wheel or becoming soiled	
Wheel size: **Wheel Style** ❒mag ❒spokes ❒	❒increase access to wheel ❒allow for seating system to fit on base	❒increase propulsion ability ❒maintenance ❒
Quick Release Wheels	❒allows wheels to be removed to decrease width of w/c for storage	❒decrease weight for lifting ❒
Wheel rims/ hand rims ❒metal ❒plastic coated ❒vertical projections ❒oblique projections	❒ Provide ability to propel manual wheelchair	❒ Increase self-propulsion with hand weakness/decreased grasp
Tires: ❒pneumatic ❒flat free inserts ❒solid	❒decrease maintenance ❒prevent frequent flats ❒increase shock absorbency	❒decrease pain from road shock ❒decrease spasms from road shock ❒
Caster housing: **Caster size:** **Style:**	❒maneuverability ❒stability of wheelchair ❒increase shock absorbency ❒durability ❒maintenance ❒angle adjustment for posture	❒decrease pain from road shock ❒decrease spasms from road shock ❒allow for feet to come under wheelchair base ❒allows change in seat to floor height ❒
Shock absorbers	❒ decrease vibration	❒ provide smoother ride over rough terrain
Spoke Protector	❒ prevent hands from getting caught in spokes	❒
One armed device ❒Left ❒Right	❒enable propulsion of manual wheelchair with one arm	❒
Anti-tippers	❒prevent wheelchair from tipping backward	❒
Amputee adapter	❒Provide support for stump/residual extremity	
❒ Crutch/cane holder **❒ Cylinder holder**	❒Stabilize accessory on wheelchair	

❒ **IV hanger**		

Brake/wheel lock extension ❒R ❒L		❒increase indep in applying wheel locks
Other:		
Other:		

SEATING COMPONENT RECOMMENDATIONS AND JUSTIFICATION

Component	Manuf/mod/size	Justification	
Seat Cushion		❒accommodate impaired sensation ❒decubitus ulcers present ❒prevent pelvic extension ❒low maintenance	❒stabilize pelvis ❒accommodate obliquity ❒accommodate multiple deformity ❒neutralize LE ❒increase pressure distribution ❒
Seat Wedge		❒accommodate ROM	❒Provide increased aggressiveness of seat shape to decrease sliding down in the seat
Cover Replacement		❒protect back or seat cushion	❒
Mounting hardware lateral trunk supports headrest medial thigh support back seat	fixed swing away for:	❒attach seat platform/cushion to w/c frame ❒attach back cushion to w/c frame	❒mount headrest ❒swing medial thigh support away ❒swing lateral supports away for transfers
Seat Board **Back Board**		❒support cushion to prevent hammocking	❒ allows attachment of cushion to mobility base
Back		❒provide lateral trunk support ❒accommodate deformity ❒accommodate or decrease tone ❒facilitate tone	❒provide posterior trunk support ❒provide lumbar/sacral support ❒support trunk in midline ❒
Lateral pelvic/thigh support		❒ pelvis in neutral ❒accommodate pelvis ❒position upper legs	❒accommodate tone ❒removable for transfers ❒
Medial Knee Support		❒decrease adduction ❒accommodate ROM	❒remove for transfers ❒alignment
Foot Support		❒position foot ❒accommodate deformity	❒stability ❒decrease tone ❒control position
Ankle strap/heel loops		❒support foot on foot support ❒decrease extraneous movement	❒provide input to heel ❒protect foot
Lateral trunk Supports	❒R ❒L	❒decrease lateral trunk leaning ❒accom asymmetry ❒contour for increased contact	❒safety ❒control of tone ❒
Anterior chest strap, vest, or shoulder retractors		❒decrease forward movement of shoulder ❒accommodation of TLSO decrease forward movement of trunk	❒added abdominal support ❒alignment ❒assistance with shoulder control ❒decrease shoulder elevation ❒

Patient Name:

Patient Name:

Component	Manuf/mod/size	Justification	
Headrest		❒provide posterior head support ❒provide posterior neck support ❒provide lateral head support ❒provide anterior head support ❒support during tilt and recline ❒improve feeding	❒improve respiration ❒placement of switches ❒safety ❒accommodate ROM ❒accommodate tone ❒improve visual orientation
Neck Support		❒decrease neck rotation	❒decrease forward neck flexion
Upper Extremity Support Arm trough Posterior hand support ½ tray full tray swivel mount	❒R ❒L	❒decrease edema ❒decrease subluxation ❒control tone ❒provide work surface ❒placement for AAC/Computer/EADL	❒decrease gravitational pull on shoulders ❒provide midline positioning ❒provide support to increase UE function ❒provide hand support in natural position
Pelvic Positioner Belt SubASIS bar Dual Pull		❒stabilize tone ❒decrease falling out of chair/ **will not decrease potential for sliding due to pelvic tilting ❒prevent excessive rotation	❒pad for protection over boney prominence ❒prominence comfort ❒special pull angle to control rotation ❒
Bag or pouch		**Holds:** ❒medicines ❒special food ❒orthotics ❒clothing changes	❒diapers ❒catheter/hygiene ❒ostomy supplies ❒
Other			

Patient/Client/Caregiver Signature:		**Date:**
Therapist Name Printed:		
Therapist's Signature		**Date:**
Supplier's Name Printed:		
Supplier's Signature:		**Date:**

I agree with the above findings and recommendations of the therapist and supplier:

Physician's Name Printed:		
Physician's Signature:		**Date:**

This is to certify that I, the above signed therapist have the following affiliations:

❒ This DME Provider
❒ Manufacturer of Recommended Equipment
❒ Patient's Long Term Care Facility
❒ None of the above